

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18857

State File No.

Registrar's No.

FILED JUN 14 1943

Primary Registration District No. 6026

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Reynolds
(b) City or town Rural - Black River
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
10 miles west of Black
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days)

3. (a) PRINT FULL NAME hova Bell Volner

3. (b) If veteran, name war ✓ 3. (c) Social Security No. none

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Amos Volner 6. (c) Age of husband or wife if alive 5-1 years
7. Birth date of deceased Feb 16 1889 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
54 3 17 hr. _____ min.

9. Birthplace Black (City, town, or county) mo. 0 (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

12. Name Jubilee L. Barton
13. Birthplace unknown (City, town, or county) 9 (State or foreign country)
14. Maiden name Margie Smith
15. Birthplace unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant Amos Volner
(b) Address Black mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-4-43 (Month) (Day) (Year)

(c) Place: burial or cremation Black mo.

18. (a) Signature of funeral director none

(b) Address _____

19. (a) 6-4 1943 (Date received local registrar) (b) Mrs. Mary Wellington (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Reynolds
(c) City or town Rural - Black River (If outside city or town limits, write "RURAL")
(d) Street No. 10 miles west of Black (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 3rd
year 1943 hour 7 minute 00 P. M.

21. I hereby certify that I attended the deceased from May 1942 to June 3 1943
that I last saw her alive on May 25 and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy

Due to Hypertension

Due to _____

Other conditions. (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)

While at work? _____ Means of injury _____

Signature E. M. Fitzpatrick (M. D. or other) MD

Address Reynolds mo Date signed 6/3/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 5,

District File Number

Date Filed

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

Registered Apprentice No.

working under my personal supervision.

Signed

Licensed Embalmer No.

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.